FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046235

Facility Name: DOCTORS NURSING & REHABILITATION CENTER

Address: 1201 HAWTHORN ROAD (Number) SALEM (City) 62881 (Zip Code)

County: MARION

Telephone Number: (217) 528-0044 **Fax #** (217) 528-3412

IDPA ID Number: 412079162001

Date of Initial License for Current Owners: 05/01/2003

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROBERT HEDGES
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,636	562	8,277	13,475	8
9	SNF/PED					9
10	ICF	20,257	4,012	316	24,585	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,893	4,574	8,593	38,060	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.89%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

I. On what date did you start providing long term care at this location?

Date started 05/01/03

J. Was the facility purchased or leased after January 1, 1978?

YES [x] Date 03/01/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?

YES [x] NO [ ] If YES, enter number of beds certified 120 and days of care provided 7,621

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DOCTORS NURSING & REHABILITATIO # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	133,033	20,239	11,285	164,557		164,557		164,557			1
2	Food Purchase		144,050		144,050		144,050	(2)	144,048			2
3	Housekeeping	76,697	22,532		99,229		99,229		99,229			3
4	Laundry	49,240	16,059		65,299		65,299		65,299			4
5	Heat and Other Utilities			141,831	141,831		141,831	1,181	143,012			5
6	Maintenance	28,216	12,751	20,443	61,410		61,410	9,099	70,509			6
7	Other (specify):*			9,292	9,292		9,292		9,292			7
8	TOTAL General Services	287,186	215,631	182,851	685,668		685,668	10,278	695,946			8
	B. Health Care and Programs											
9	Medical Director			23,400	23,400		23,400		23,400			9
10	Nursing and Medical Records	1,601,210	215,318	46,724	1,863,252		1,863,252		1,863,252			10
10a	Therapy	243,199	780	221	244,200		244,200		244,200			10a
11	Activities	34,909	1,778		36,687	1,352	38,039		38,039			11
12	Social Services	41,856		5,777	47,633		47,633		47,633			12
13	CNA Training											13
14	Program Transportation			11,851	11,851		11,851		11,851			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,921,174	217,876	87,973	2,227,023	1,352	2,228,375		2,228,375			16
	C. General Administration											
17	Administrative	85,110		402,918	488,028		488,028	(301,472)	186,556			17
18	Directors Fees											18
19	Professional Services			82,967	82,967		82,967	(59,193)	23,774			19
20	Dues, Fees, Subscriptions & Promotions			27,218	27,218		27,218	(9,599)	17,619			20
21	Clerical & General Office Expenses	102,495	14,657	19,829	136,981		136,981	7,477	144,458			21
22	Employee Benefits & Payroll Taxes			363,313	363,313		363,313		363,313			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,183	1,183		1,183	2,974	4,157			24
25	Other Admin. Staff Transportation			13,510	13,510	(1,352)	12,158	(9,704)	2,454			25
26	Insurance-Prop.Liab.Malpractice			81,718	81,718		81,718	2,713	84,431			26
27	Other (specify):*			40,306	40,306		40,306	(17,231)	23,075			27
28	TOTAL General Administration	187,605	14,657	1,032,962	1,235,224	(1,352)	1,233,872	(384,035)	849,837			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,395,965	448,164	1,303,786	4,147,915		4,147,915	(373,757)	3,774,158			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: DOCTORS NURSING & REHABILITATION CENT #0046235 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,285	
	REPAIRS & MAINTENANCE		0	
			0	11,285
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		50,227	
	ELECTRICITY		44,029	
	WATER		42,110	
	CABLE TV - LOBBY		5,465	
			0	141,831
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,016	
	PAINTING & DECORATING		515	
	BUILDING REPAIRS		6,276	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5,838	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,305	
	FIRE SERVICE		2,493	
			0	
			0	
			0	20,443
7	**OTHER**			
	SCAVENGER		9,292	
	SECURITY SERVICE		0	9,292
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	23,400	23,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		41,365	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,699	
	PHARMACY CONSULTANT	XVIII B 39-2	3,660	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	46,724
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	221	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	221
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		1,232	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,545	
			0	5,777
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER #0046235 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		11,851	11,851
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	402,918	402,918
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	7,193	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	75,774	
			0	82,967
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	10,239	
	EMPLOYEE WANT ADS	XIX F	852	
	CONTRIBUTIONS	VI 20 XIX F	360	
	DUES & SUBSCRIPTIONS	XIX F	10,634	
	LICENSES & PERMITS	XIX F	2,667	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,466	27,218
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		4,904	
	EQUIPMENT REPAIR & MAINTENANCE		1,352	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		13,573	
	MESSENGER SERVICE		0	
			0	19,829

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	181,086	
	UNEMPLOYMENT COMPENSATION	XIX D	52,895	
	WORKERS COMPENSATION INSURANCI	XIX D	92,951	
	HOSPITALIZATION INSURANCE	XIX D	22,287	
	EMPLOYEE BENEFITS - OTHER	XIX D	14,094	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	363,313
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,183	
	TRAVEL	XIX G	0	
			0	
			0	1,183
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		13,510	13,510
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		81,718	81,718
27	**OTHER**			
	BAD DEBTS	VI 24	40,306	
				40,306

GRAND TOTAL COLUMN 3 OTHER 1,303,786

DOCTORS NURSING & REHABILITATION CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	144,050	PATIENT MEALS	114180
LESS SALES TAX	(2)	ADD EMPLOYEE MEALS	0
NET FOOD	144,048	TOTAL MEALS/YEAR	114180
TOTAL PATIENT CENSUS	38,060	NET FOOD	144048
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	114180
TOTAL PATIENT MEALS	114180	COST PER MEAL	1.26
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER #0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			10,073	10,073		10,073	(2,767)	7,306			30
31	Amortization of Pre-Op. & Org.			1,400	1,400		1,400		1,400			31
32	Interest			20,160	20,160		20,160	(1,251)	18,909			32
33	Real Estate Taxes			41,548	41,548		41,548		41,548			33
34	Rent-Facility & Grounds			445,300	445,300		445,300		445,300			34
35	Rent-Equipment & Vehicles			156,187	156,187		156,187		156,187			35
36	Other (specify):* **Amort comp soft**			9,197	9,197		9,197		9,197			36
37	**TOTAL Ownership**			683,865	683,865		683,865	(4,018)	679,847			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		399,668	418,175	817,843		817,843		817,843			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		399,668	483,875	883,543		883,543		883,543			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,395,965	847,832	2,471,526	5,715,323		5,715,323	(377,775)	5,337,548			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,748)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2)	2		13
14	Non-Care Related Interest	(2,951)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(360)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,306)	27		24
25	Fund Raising, Advertising and Promotional	(10,239)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(93,753)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (151,359)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(226,416)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (226,416)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (377,775)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

DOCTORS NURSING & REHABILITATION CENTER

ID# 0046235

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	MARKETING SALARY	(18,910)	21	2
3	BANK CHARGES	(4,904)	21	3
4	LEGAL - BRANSON, JONES & STEDELIN	(275)	19	4
5	MARKETING CONSULTANT-HI CARE MGMT	(9,000)	19	5
6	DATA PROCESSING-HEALTHCARE HORIZONS	(50,960)	19	6
7	TRAVEL - MARKETING	(9,704)	25	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(93,753)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER **#** 0046235 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2)	0	0	0	0	0	0	0	0	0	0	(2)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,181	0	0	0	0	0	0	0	0	0	1,181	5
6	Maintenance	0	9,099	0	0	0	0	0	0	0	0	0	9,099	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2)	10,280	0	0	0	0	0	0	0	0	0	10,278	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(301,472)	0	0	0	0	0	0	0	0	0	(301,472)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(60,235)	1,042	0	0	0	0	0	0	0	0	0	(59,193)	19
20	Fees, Subscriptions & Promotions	(10,599)	1,000	0	0	0	0	0	0	0	0	0	(9,599)	20
21	Clerical & General Office Expenses	(23,814)	31,291	0	0	0	0	0	0	0	0	0	7,477	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,974	0	0	0	0	0	0	0	0	0	2,974	24
25	Other Admin. Staff Transportation	(9,704)	0	0	0	0	0	0	0	0	0	0	(9,704)	25
26	Insurance-Prop.Liab.Malpractice	0	2,713	0	0	0	0	0	0	0	0	0	2,713	26
27	Other (specify):*	(40,306)	23,075	0	0	0	0	0	0	0	0	0	(17,231)	27
28	**TOTAL General Administration**	(144,658)	(239,377)	0	0	0	0	0	0	0	0	0	(384,035)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(144,660)	(229,097)	0	0	0	0	0	0	0	0	0	(373,757)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,748)	0	981	0	0	0	0	0	0	0	0	(2,767)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,951)	0	1,700	0	0	0	0	0	0	0	0	(1,251)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,699)	0	2,681	0	0	0	0	0	0	0	0	(4,018)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(151,359)	(229,097)	2,681	0	0	0	0	0	0	0	0	(377,775)	45

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				HI CARE	SPRINGFIELD	MANAGEMENT
				MANAGEMENT		
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 402,918	HI CARE MANAGEMENT		$	$ (402,918)	1
2	V	5	UTILITIES				1,181	1,181	2
3	V	6	MAINTENANCE				9,099	9,099	3
4	V	17	OFFICER'S SALARY				74,240	74,240	4
5	V	17	DIRECTOR OF OPERATIONS				10,235	10,235	5
6	V	17	DIRECTOR OF FINANCE				16,971	16,971	6
7	V	19	PROFESSIONAL FEES				1,042	1,042	7
8	V	20	DUES & SUBSCRIPTIONS				1,000	1,000	8
9	V	21	OFFICE EXPENSE				31,291	31,291	9
10	V	24	TRAVEL & SEMINARS				2,974	2,974	10
11	V	26	INSURANCE				2,713	2,713	11
12	V	27	PAYROLL TAXES/GROUP INS				23,075	23,075	12
13	V								13
14	Total			$ 402,918			$ 173,821	$ * (229,097)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	H & I PRPERTIES		$ 981	$ 981	15
16	V	32	INTEREST		H & I PRPERTIES		1,700	1,700	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 2,681	$ * 2,681	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DOCTORS NURSING & REHABILITATIC # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.						$		1
2	TOTAL SALARY RECEIVED FROM HI CARE $170,000			37.5%				SALARY	37,120	17-8	2
3											3
4											4
5											5
6	WILLIAM IRVINE	VICE-PRESIDENT	OFFICE MGMT.								6
7	TOTAL SALARY RECEIVED FROM HI CARE $170,000			37.5%				SALARY	37,120	17-8	7
8											8
9											9
10											10
11	MARTHA IRVINE										11
12	TOTAL SALARY RECEIVED FROM HI CARE $6672								1,457	21-8	12
13								TOTAL	$ 75,697		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HI CARE MANAGEMENT
Street Address: 1625 SOUTH SIXTH STREET
City / State / Zip Code: SPRINGFIELD IL. 62703
Phone Number: (217)528-0044
Fax Number: (217)528-3412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	174,304	7	$ 5,408	$	38,060	$ 1,181	1
2	6	MAINTENANCE	PER RESIDENT DAY	174,304	7	41,669	34,507	38,060	9,099	2
3	17	OFFICER SALARY	PER RESIDENT DAY	174,304	7	340,000	340,000	38,060	74,240	3
4	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	174,304	7	46,873	46,873	38,060	10,235	4
5	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	174,304	7	77,723	77,723	38,060	16,971	5
6	19	PROFESSIONAL FEES	PER RESIDENT DAY	174,304	7	4,774		38,060	1,042	6
7	20	DUES & SUBSRIPTION	PER RESIDENT DAY	174,304	7	4,580		38,060	1,000	7
8	21	OFFICE EXPENSE	PER RESIDENT DAY	174,304	7	143,304	89,662	38,060	31,291	8
9	24	TRAVEL & SEMINARS	PER RESIDENT DAY	174,304	7	13,622		38,060	2,974	9
10	26	INSURANCE	PER RESIDENT DAY	174,304	7	12,425		38,060	2,713	10
11	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	174,304	7	105,677		38,060	23,075	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 796,055	$ 588,765		$ 173,821	25

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: H & I PROPERTIES
Street Address: 1625 S SIXTH STREET
City / State / Zip Code: SPRINGFIELD IL 62703
Phone Number: (217)528-0044
Fax Number: (217)528-0412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	PER LICENSE BED	639	7	$ 5,226	$	120	$ 981	1
2	32	INTERES	PER LICENSE BED	639	7	9,051		120	1,700	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 14,277	$		$ 2,681	25

Facility Name & ID Number DOCTORS NURSING & REHABILITATIO # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3	related party office-us bank		X	MORTGAGE					6/29/12	0.0635	1,700	3
4	MEMBER LOANS	X						100,000			7,000	4
5	ILLINI BANK		X	WORKING CAPITAL	$2,107.00	9/25/03	100,000	60,701	09/25/08	0.0950	6,789	5
	Working Capital											
6	ILLINI BANK		X	WORKING CAPITAL	INTEREST			235,000	REVOLV	PRIME +	5,563	6
7	MARINE BANK		X	BUS	$594.00	05/19/04	19,500	9,645	06/19/07	0.0600	808	7
8												8
9	TOTAL Facility Related				$2,701.00		$ 119,500	$ 405,346			$ 21,860	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 119,500	$ 405,346			$ 21,860	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	36,894	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	39,221	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,327	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	39,221	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	41,548	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001		9
2002	36,986	10
2003	36,893	11
2004	39,221	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOCTORS NURSING & REHABILITATION CENTER COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0046235

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-03-000-004	NURSING HOME	$ 38,943.48	$ 38,943.48
2.	11-03-400-003	NURSING HOME	$ 159.52	$ 159.52
3.	11-03-400-004	NURSING HOME	$ 117.80	$ 117.80
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,220.80	$ 39,220.80

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 7,000
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 1,400
4. Dates Incurred: 03/01/03

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WATER HEATER			2003	6,135	223	27.5	223		511	9
10	WATER HEATER			2004	8,145	296	27.5	296		534	10
11	TILING			2005	4,980	98	27.5	98		98	11
12	SIDEWALK			2005	6,300	210	15	210		210	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	H & I PROPERTIES-OFFICE BUILDING			2005	49,376	981	39	981		981	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 74,936	$ 1,808		$ 1,808	$	$ 2,334	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CEN # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 7,123	$ 1,140	$ 712	$ (428)	10 YRS	$ 1,068	71
72	Current Year Purchases	3,729	746	186	(560)	10 YRS	186	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 10,852	$ 1,886	$ 898	$ (988)		$ 1,254	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2001 CHEVY EXPRESS BUS	2004	$ 23,000	$ 7,360	$ 4,600	$ (2,760)	5 YRS	$ 9,200	76
77										77
78										78
79										79
80	TOTALS			$ 23,000	$ 7,360	$ 4,600	$ (2,760)		$ 9,200	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 108,788	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,054	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 7,306	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,748)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 12,788	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SALEM ASSOCIATES, LTD

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		120	2/28/03	$ 445,300	10		3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 445,300 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 04/01/03
Ending 02/28/13

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$ 445,300
13.	/2007	$ 445,300
14.	/2008	$ 445,300

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 156,187 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 141,999	$		$ 141,999	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			83,498			83,498	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			192,678			192,678	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				311,722		311,722	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): oxygen	39-8					87,946		87,946	13
14	TOTAL			$		$ 418,175	$ 399,668		$ 817,843	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 44,239	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (150,000))	1,174,876		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,152		6
7	Other Prepaid Expenses	42,820		7
8	Accounts Receivable (owners or related parties)	109,700		8
9	Other(specify): Due from Prior Owner	109,021		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,558,808	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	25,560		15
16	Equipment, at Historical Cost	61,444		16
17	Accumulated Depreciation (book methods)	(45,527)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,967)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 44,510	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,603,318	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 550,929	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	305,346		29
30	Accrued Salaries Payable	83,390		30
31	Accrued Taxes Payable (excluding real estate taxes)	40,515		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,221		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,019,401	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	MEMBERS LOANS	100,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 100,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,119,401	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 483,917	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,603,318	$	48

***(See instructions.)**

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 557,779	1
2	Restatements (describe):		2
3	**POST CLOSING ENTRIES**	(29,446)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 528,333	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	348,666	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(393,082)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (44,416)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 483,917	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CEI # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,689,414	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,689,414	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	371,624	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 371,624	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,951	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,951	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,063,989	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	685,668	31
32	Health Care	2,227,023	32
33	General Administration	1,235,224	33
	B. Capital Expense		
34	Ownership	683,865	34
	C. Ancillary Expense		
35	Special Cost Centers	817,843	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,715,323	40
41	**Income before Income Taxes (line 30 minus line 40)****	348,666	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 348,666	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,337	1,572	$ 49,124	$ 31.25	1
2	Assistant Director of Nursing	3,723	4,192	83,497	19.92	2
3	Registered Nurses	15,137	16,553	309,737	18.71	3
4	Licensed Practical Nurses	27,009	29,243	472,139	16.15	4
5	CNAs & Orderlies	61,421	64,503	584,655	9.06	5
6	CNA Trainees					6
7	Licensed Therapist	11,003	12,161	201,336	16.56	7
8	Rehab/Therapy Aides	3,401	4,149	41,863	10.09	8
9	Activity Director	1,735	1,992	21,717	10.90	9
10	Activity Assistants	1,671	2,006	13,192	6.58	10
11	Social Service Workers	3,017	3,282	41,856	12.75	11
12	Dietician					12
13	Food Service Supervisor	1,870	2,046	22,179	10.84	13
14	Head Cook	5,329	5,979	44,334	7.41	14
15	Cook Helpers/Assistants	9,401	10,144	66,520	6.56	15
16	Dishwashers					16
17	Maintenance Workers	1,953	2,158	28,216	13.08	17
18	Housekeepers	9,337	16,584	76,697	4.62	18
19	Laundry	6,337	7,064	49,240	6.97	19
20	Administrator	1,823	2,095	85,110	40.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,792	2,155	36,747	17.05	23
24	Clerical	4,311	4,786	65,748	13.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	864	2,035	19,632	9.65	31
32	Other Health C: MDS, Central Sup	4,553	4,065	82,426	20.28	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,024	198,764	$ 2,395,965 *	$ 12.05	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly fees	$ 11,285	1-3	35
36	Medical Director	monthly fees	23,400	9-3	36
37	Medical Records Consultant	monthly fees	1,699	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fees	3,660	10-3	39
40	Physical Therapy Consultant	monthly fees	221	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	monthly fees	4,545	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 44,810		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENT # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KYLE MOORE	ADMIN		$ 85,110
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 85,110

B. Administrative - Other

Description	Amount
HI CARE MANAGEMENT	$ 402,918
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 402,918

C. Professional Services

Vendor/Payee	Type	Amount
ACHIEVE HEALTHCARE	DATA PROCESSING	$ 7,193
KRUPNICK, BOKOR	ACCOUNTING	17,800
RICHARD PEELO	MEDICARE CONSULTANT	3,000
BRANSON, JONES & STEDELIN	LEGAL	1,580
HEALTHCARE HORIZON	DATA PROCESSING	50,960
PERSONNEL PLANNER	UC CONSULTANT	2,234
PENSION ADMINISTRATORS INC	PENSION ADMINISTRATOR	200
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 82,967

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,951
Unemployment Compensation Insurance	52,895
FICA Taxes	181,086
Employee Health Insurance	22,287
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	14,094
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 363,313

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	852
Health Care Worker Background Check	2,466
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	10,239
TRUST/FRANCHISE/CONTRIB/ETC	360
LICENSES & PERMITS	677
DUES & SUBSCRIPTIONS	10,634
MGMT CO ALLOCATION	1,000
TRUST/FRANCHISE/CONTRIB/ETC	(360)
Less: Public Relations Expense	(0)
Non-allowable advertising	(10,239)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,619

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	2,974
Seminar Expense	
	1,183
MGMT CO ALLOC	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,157

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTHCARE ASSOCIATION $6,624**

(3) Did the nursing home make political contributions or payments to a politica
action organization? _____ If YES, have these costs
been properly adjusted out of the cost report? **NO**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **6,638** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees